

Practical strategies to develop a customer-centric hospital case management model

The realities of health care today emphasize the need to demonstrate measurable bottom-line outcomes. But **Stefani Daniels, RN, MSNA**, managing partner of PHOENIX Medical Management based in Pompano Beach, FL, argues that with physicians driving upwards of 80% of resource costs, it is equally important for case managers to understand how the challenges confronting doctors and hospitals can be leveraged by case managers to create program value for enhanced funding and a competitive advantage.

Sheila Hawley, MSN, case manager at CMH Regional Health System in Wilmington, Ohio, says that employing this approach throughout every department of the hospital has made a “phenomenal” difference. “Everybody had a different view of what a case manager should be,” she explains. “When the doctor is your ‘customer’ and they know you are there to help them, it is a totally different ball game.”

To maximize their effectiveness, Daniels says case managers must understand transformations in today’s health care environment. Not only do patients no longer trust the healthcare system, doctors and hospital administrators rarely trust each other, says Daniels. “There used to be a point in time where doctors and administrators worked together,” she says. But that has been replaced by an adversarial relationship that also includes payers.

Worse yet, the doctor-patient relationship had become a myth, argues Daniels. The average time that a doctor spends with a patient is six

minutes. "What kind of relationship can you build in a six-minute interview," she asserts.

According to Daniels, the biggest single biggest challenge facing the medical profession is variation among practice patterns for the same type of patient. One recent example of this that made headlines was a finding that many women with certain types of breast cancer faced radical mastectomy, even though all the evidence showed similar outcomes could be achieved when treated with a lumpectomy she says.

The reason for this variation is threefold, says Daniels. The first is resource availability . "If you have an MRI, physicians will use the MRI whether it is appropriate or not, she maintains. The other two factors are geographic, namely where they went to school and where they did their residency. "In medicine, geography is destiny," she asserts.

Daniels maintains that while the increasingly competitive health care environment is magnifying these trends, it is also presents opportunities to providers. "Consumer power is giving rise to new opportunities," she argues. "Consumer expectations are going to shape the conduct and the performance of the hospital in the future and there is a window of opportunity."

Moreover, Daniels says case managers can leverage these environmental pressures by exploiting the demand for value by applying customer-centric trends to case management programs. And that means aligning the program with the expectations of the primary customer, which is, contrary to conventional wisdom, the physician. "Without the physician, you will not have a patient," argues Daniels, adding that despite the impact of managed care, physicians direct 60% of hospital admissions..

When case managers look at physicians as their primary customer, the benefits that result are numerous including physician loyalty and

greater market share. Moreover, if case managers influence the way physicians practice it ultimately benefits patients, argues Daniels.

Bringing this about is no easy task, however. Daniels says that it requires a radical shift in thinking about the purpose of the case management program and many of the traditional activities typically performed in case management departments as well as strategies used to influence physicians without interfering with clinical judgment.

Once positioned and oriented as a value-added service to engage the physician and establish an individualized partnership, Daniels says the case manager has the opportunity to offer advice, provide essential information, and, most importantly, suggest acceptable practice alternatives.

“Together as a team, our primary customer then becomes the patient,” says **Marianne Ramey, RN, CCM**, a partner in the same firm. But while that sounds very nice and looks good on paper, making it happen on a real-time, everyday basis is another matter, she adds.

Here are some of the tools case managers can employ to facilitate this shift Ramey.

For starters, many case management programs have generic mission statements, if they have one at all. Ramey maintains that case management programs need to review their vision for case management and their purpose for being case managers.

Programs should then look at their structure, says Ramey. “What you started with a few years ago might not be adequate anymore,” she explains. “If we are going to truly be able to partner with the physician, something has to change.”

For example, she says it is difficult for case managers to act as a real partner to the physician if they have their nose buried in the chart doing utilization review instead of making rounds with the physician.

In roughly three-quarters of the programs it designs, PHOENIX uses clerical staff to perform contractual UR. "Utilization review is a legacy activity that must be performed due to contractual obligations," says Daniels. "But once you reach a point where you can demonstrate reduced denials, the hospital has the negotiating power to eliminate the onerous utilization language in the contract."

When it comes to staff reorientation, the old way of doing things may not apply in a customer centric model either, says Ramey. "If you are truly going to be a partner for the physician, if you are going to be customer-focused, you must be there for your customer."

In terms of practical application, that requires a shift in behaviors and perhaps even appearance. For example, wearing lab coats out on the floor lends a clinical appearance, she suggests. "Perhaps we need to focus our actions and our behaviors in more of a business alignment and ditch the lab coats," Ramey asserts

Perhaps the most fundamental change that must occur is a shift in day-to-day activities, according to Ramey. Simply put, she says case managers must perform in terms of achieving goals rather than completing tasks. If the case manager is to influence physician practice decisions to achieve desired clinical and economic outcomes, the case manager must be readily available for their primary customers – the physician.

Ramey says that as long as case managers have their your heads buried in the chart and lack support staff, she says the chances are they will spend most of their time on administrative functions such as making sure the information is right on the face-sheet, hunting for post acute benefit resources, waiting on hold to pass on utilization information to the payer.

"We are not going to be able to round with our physicians," she says. "We are not going to be able to meet with our patients and families."

"The idealistic model of caring only about the patient is gone," argues Ramey. "Case managers must prove their value to the team with numbers, not feelings." Collecting data on avoidable days is one example that can demonstrate a measurable outcome and lead to organizational change, she says.

On the other hand, if the organization is not going to do anything with that information, don't collect it. "Before you throw it out, take a look at what that information might be saying," she adds. The chances are that it points to numerous barriers that exist within your organization. "I am betting that those who get denied day information can correlate their avoidable days directly with their denied days," she explains. "They can predict when they are going to happen."

According to Daniels, the other popular myth is that length of stay is an accurate barometer of effective case management. "Don't be lulled into a false sense of accomplishment" she says. "Cost per case is a more precise measure."

Ramey says that by decreasing length of stay, providers often cram the same amount services into a shorter period of time. "We got more efficient in providing services that may not have needed to be done in the acute care setting the first place," she argues. "Or, of even greater clinical significance, shouldn't have been done in the first place if evidence based medicine were practiced."

"Hospital case management programs must continue to evolve," Daniels says. "Inevitably, that may require additional financial and human resources." Unless the case management program can demonstrate

measurable value in terms of economic bottom line outcomes, there is very little chance that the CFO will endorse further resources, she says.

“Organizations put a lot of money in their case management program and what you want to be able to do is demonstrate a return on that investment,” says Daniels. “That will generate even more investment.”